STUDENT MEDICAL DIETARY REQUIREMENT FORM

CHRISTENDOM COLLEGE

Part A: To be Completed by Parent/Guardian

Student Name: ____

Address: ____

I give permission for my Physician/Health Care Professional to furnish Christendom College with medical and/or health information that would indicate my son's/daughter's need for special dietary consideration.

______________________________ ____________________

Parent/Guardian signature Date

Part B: To Be Completed By Physician

I certify that the student listed above is my patient and has a medical condition which necessitates the special dietary requirements listed below:

A) The patient's dietary requirements are the following:

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B) These requirements come from the following medical and/or health condition:

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______________________________ ____________________

Physician signature Date

Practice Name/Address/Tele # ____

Please Return This Form To:

CHRISTENDOM COLLEGE
ATTN: VP FOR OPERATIONS
134 CHRISTENDOM DRIVE
FRONT ROYAL, VA 22630